

**Meeting Minutes of  
The Governor's Council on Behavioral Health  
8:30 AM – February 9, 2012**

The Governor's Council on Behavioral Health met at 8:30 a.m. on Thursday, February 9, 2012 at Barry Hall's conference room 126, 14 Harrington Road, Cranston RI 02920.

Members Present: Rich Leclerc, Chair, Michelle Brophy, Linda Bryan, Cathy Ciano, Ed Congdon, Stephanie Culhane, Mark Fields, Jim Gillen, Bruce Long, Anne Mulready, and Neil Corkery.

Ex-Officio Members Present: Janice DeFrances, Director, Janet Anderson, Department of Children, Youth and Families (DCYF); Lou Cerbo, Department of Corrections (DOC), Deb Garneau, Health Department (DOH), Sharon Kernan, Department of Human Service (DHS), Craig Stenning, Director, Charles Williams and Rebecca Boss, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).

Guests: David Dorsey, James Plante, Linda Mambro, Jessica Mowry, Amy Shultz, Marie Waldek, and Vivian Weismann.

Staff: James Dealy, Linda Harr and Lisa Stevens

Once a quorum was established and introductions were made, the Chair, Richard Leclerc, called the meeting to order at 8:35 a.m. Richard entertained a motion to accept the minutes of January 10, 2012. Bruce Long motioned and Jim Gillen seconded. Richard called for a vote to approve the minutes. All were in favor, and the minutes were approved as written.

**Updates from DCYF:** Janet Anderson presented. She said that the Department continues to operate under the best practice model of working with children in their homes wherever possible and, if that isn't possible, then as close to home as possible. Ten years ago the number of kids in out of state care was about 300, while today it is 50. Most of these are in nearby Mass. This progress is the result of working closely and collaboratively with the Department's providers to review the needs of kids who are out of state and to try to develop the programs here to get them closer to home. Janet said that the Department and the community should be applauded for their efforts.

The FCCP program began in 2005 with a letter of interest to community agencies to develop evidence based, home-based services as alternatives to out-of-home placements. The implementation of the FCCP's has contributed to the dramatic shift from out-of-state to in-state placements as well as to strengthening community-based services. This has happened in spite of several years of budget cuts.

Dr DeFrances stated that when the System of Care funding that has supported much of this systems development ends, there will be a very strong foundation for continued partnership with the two networks. DCYF wants to make sure that there will continue to be an array of services to meet the needs of children and families, that it can continue to put resources back into the community and that it can appropriately fund providers to provide high quality evidence based practices.

July 1, 2012 is the target date for the Department and the networks to roll out the new FCCP II system of care. DCYF is concerned that the program have sustainable support in this era of tight budgets. The Department and the network providers have had to spent time negotiating sustainable rates, and the providers have been quite accommodating during this process. When the new rates go out, Dr. DeFrances said they will be transparent and, hopefully, will be seen as equitable.

Janet presented the Department's perspective on the budget cuts to the Kids Link program. Kids Link, a DCYF-funded service of Gateway HC, provided a statewide hotline that anybody with a child in mental health crisis could call, regardless of insurance coverage. It included an immediate clinical phone assessment and access, if needed, to a face-to-face appointment and timely clinical follow up as an alternative to an emergency room visit and to unnecessary hospitalization. Janet said that the Department's decision to eliminate the central 866 contact number for all child psychiatric emergencies was very hard to make. The Department has been working to adjust to budget cuts while still trying to meet the program's goals. DCYF intends that the network of currently certified providers will pick up the work of the call center and is close to issuing certification standards for diversion services that it hopes will expand the provider network. It is refining regulations to govern certification for these providers. Certifications require that a child and family competent clinician be available for a live phone assessment within 15 minutes of a crisis call. The clinician will then determine if a face to face meeting is needed. Funding for this service creates challenges for providers, and they are looking at collaborations to share costs. Until the current round of applications for provider certification is done, Rich noted, it isn't clear how many providers will want to take on this service in the absence of the supports provided by Kids Link.

Another issue that will have to be addressed is the quality of data formerly generated by Kids Link. Having one call site and a contracted agency responsible for data collection facilitated accurate data. The Department will still collect the data, but multiple agencies will now have to send it in.

The question was raised about whether ERs will continue to refer to the diversion services. Janet said that Bradley and Hasbro will be required to do so, but the other hospitals are not.

In response to a question, Janet noted that, because of a number of factors unrelated to the program, Kids Link did not produce any cost savings due to reduced ER/hospital use.

Vivian characterized the move away from Kids Link and related developments in the adult system as "stepping back" from best practices for reducing unnecessary hospitalizations. Janet noted that the children's diversion services will still be provided by the certified provider network, and that the decision to end Kids Link was a painful one, but reflected a thoughtful planning process.

Rebecca raised the issue of the CNOM for women in treatment whose kids are in DCYF custody. Sharon clarified that this is a permanent Medicaid program, not a "pilot," and that, although initially slow to start due to technical difficulties, is well underway.

**SOAR Presentation:** Jessica Mowry, R. I. SOAR (SSI/SSDI Outreach and Access to Recovery) Program Director, presented. SOAR was developed by SAMHSA and SSI in response to the fact that only 10%-15% of homeless disabled were receiving SSI/SSDI. SAMHSA provides TA, but no SOAR program money, to states. In RI, SOAR's ten full and part-time case managers are employees of a number of various agencies that serve the homeless, including the VA, DOC and homeless service providers. They do SOAR work by MOU with the state SOAR program, which provides SOAR supervision.

SOAR has demonstrated success. Nationally, the percentage of homeless, SSI/SSDI eligible people able to get benefits has gone from 10%-15% to 47%, and in RI, it is now 86%. The average time from initial application to benefits determination, which often took many months prior to SOAR, is now 90 days nationwide and 56 days in Rhode Island. SOAR is a very cost-effective program, especially for service providers who must free-care the uninsured. Rhode Island's initial SOAR pilot program in

2006 repaid Butler Hospital's \$30,000 investment in a SOAR case manager with \$197,000 in revenues. Jessica noted that the best measure of SOAR's success is the number of formerly homeless who can now afford housing and health treatment for the chronic conditions associated with their long-time homelessness.

A question was asked about what happens if a chronically homeless person drops out of working with the SOAR case manager. Jessica said that the program has close links with the homelessness service providers used by most chronically homeless people, and they haven't "lost" anyone yet. If a person does temporarily disappear, go to jail or a hospital, etc., as happens to many chronically homeless/behavioral disordered individuals, the case manager is able to act as their representative with DDS, so the disability determination can continue. Jessica said that SOAR is statewide service, and that she has been working with providers in northern and southern RI to establish more of a SOAR presence outside of the Providence area. Also, she continues to expand the "word of mouth" publicity about SOAR with homeless service providers and has begun work with the RI Coalition for the Homeless on a formal public marketing campaign. Jessica provided handouts which are attached.

**EOHHS Report:** Sharon reported progress in negotiations with CMS to develop an integrated care program for Dual (Medicaid/Medicare) Eligible consumers. EOHHS will report to the Legislature on this next week. Also, she said that the first year's outcome data on the service program for high-end ES users should be evaluated by May or June. She will report on this at the June Council meeting. Finally, Sharon reported that the Peer Navigator services that were initially grant-funded are now part of the Medicaid funded services in the Connect Care Choice program.

**BHDDH Report:** Rebecca reported. She announced a press conference to be held on 2/20 to announce a major development in connection with the Rally4Recovery. She gave updates on two Budget Initiatives: new Health Homes will be created to serve the DD and opioid dependent populations, and BHDDH is proceeding with the re-RFP of residential substance abuse services. Also, she announced that the Governor's budget proposes to raise the Thresholds housing program's budget from \$500,000 to \$800,000 and to give \$100,000 to Employment First. She announced the receipt of a National Association of State Mental Health Program Directors grant to place Employment Specialists and Peer Coaches at Anchor RC, Hillsgrove House and Harbor House. The Peer Coaches will be trained as part of the TTI initiative and will utilize the Dartmouth Model. Christine Botts will coordinate this initiative for BHDDH.

Rebecca talked about the growing awareness across state agencies of the importance to our systems of peer support practitioners. Peer support providers play a significant role in a variety of programs managed by DOH, BHDDH, EOHHS, DOC and DCYF. The departments and peer support agencies such as PSN and RIPIN have begun to discuss ways to collaborate in the future development of these peer supports, in particular around training, certification and funding. They are starting with the assumption that there are core competencies to such work, which could be the basis for a common training around which trainings for the practice-specific specialties like Peer Wellness Coaches, parent support providers, etc. can be built. BHDDH is applying to SAMHSA for a grant to send a state delegation to a Policy Academy planning session in Washington. If we get the grant, representatives of the different departments and peer groups will work on a common training plan for peer specialists. Anyone with questions or comments can contact Jim Dealy.

Janet Anderson noted that peer support services are the focus of the DCYF System of Care Expansion planning grant, which is addressing issues of training, credentialing and funding. Cathy Ciano noted

that the Federation of Families has just developed practice standards and curricula for Parent Support Providers, and urged that we take these into consideration in developing a core curriculum.

**Old/New Business:**

It was noted that, especially as the Baby Boomers age, the need to integrate behavioral health and other services to the elderly will increase. The Council, however, has no DEA representative. Rich said that the DEA Director is an ex-officio Council member, but that the current Director may not be aware of this. Charles will contact Catherine Taylor.

Michelle asked the Council members look at and comment on the state's proposed new Plan to End Homelessness during the 30-day comment period. The Plan, "Opening Doors," was sent out a few weeks ago. Jim can re-send a copy to anyone who needs it.

Rich noted that the Council has been awarded the \$20,000 TA grant that Jim wrote for to strengthen the Council's ability to plan the next combined behavioral health Block Grant.

Rebecca noted that the RI Quality Institute has been awarded \$600,000 to begin integrating behavioral health information into the state's Health Information Exchange. RIQI, which is developing a shared information base for health providers, has initially concentrated on hospital and pharmacy-based information. Behavioral healthcare will be its first specialty focus. Rebecca urged consumers to join the RI Quality Institute's Advisory Panel so as to have input into how behavioral, and especially substance-related data, is used and protected. They can contact Charles Hewitt, RIQI's Director. It was noted that NE Tech is giving free training on Health Information Technology.

The Council requested that DOH report on its Prescription Monitoring Program. Jim will work with Deb Garneau to arrange for this.

Upon motion being made and seconded, the meeting adjourned at 2:45 p.m.

The next meeting of the Council is scheduled for **1:00 PM on March 13, 2012 at Barry Hall room 126, 14 Harrington Road, Cranston RI 02920.**

Minutes respectfully recorded and written by:

Lisa Stevens

/attachments